BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

APRIL 1933.

GENERAL NOTES.

We congratulate Surgeon-General C. A. Sprawson on his appointment as the Director-General of the Indian Medical Service. If, high professional attainments, academic distinction and varied administrative experience be the requirements for the post, the Government of India could not have made a better choice. We are proud that Madras has provided three Directors-General successively. But we cannot help expressing our regret that so able and fair-minded an officer as the present Surgeon General is to be lost to Madras so soon. This is not the occasion to appreciate his services to us, but we are sure, that the medical profession, particularly that large section which is outside the various services, would feel sorely the loss from their midst of an administrator who has such a true perception of the medical needs of the Presidency.

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We congratulate Dr. M. R. Guruswami Mudaliar on his appointment as Professor of Medicine in the local Medical College. This is the first time that an Indian has been privileged to occupy the chair of Medicine in Madras. We feel confident that Dr. Guruswami Mudaliar would maintain the dignity of the chair of Medicine.

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We understand that orders have been received from the Secretary of State for India to abolish the numerical order of physicians and surgeons in the Government General Hospital. When these officers were numbered in the order of their seniority there was some justification for calling them first physician or surgeon, second, and third. But as this principle is not followed in the appointments, it would be unfair to retain the numbering. Their method of particularising the different officers as first, second and third physicians or surgeons has been peculiar to Madras. In all other countries all the physicians and surgeons are considered equal in rank, their importance depending entirely on their professional merit. We are therefore glad that this absurd arrangement has been abolished.

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The Indian Medical Council Bill in its new form was introduced in the Assembly and has been sent to a Select Committee. This bill has turned out to be the proverbial mountain in travail. All the tall talk about maintaining the efficiency of medical education and unifying their standard has been silently given up. The real and the only purpose of the proposed council is to be the appointment of Inspectors to report on the various medical schools and colleges to the British Medical Council—certainly through the Government of India. This new council need not even maintain a register of its own! The Government of India proposed to appoint these inspectors when the British Medical Council refused to recognize Indian Medical qualifications. The British Medical Council would not then agree to the proposal. Is this mighty council climbing down to pick up the offering which in its arrogance it had once kicked down?

* * *

Our members would be pleased to learn that Dr. C. R. Krishnaswami, the General Secretary of the Union has come out successful in the recent M.S. Degree examination of the Madras University. Our congratulations to him on his well-merited achievement. We sincerely hope that his example would influence our younger members to exert themselves to acquire higher degrees of our University.

EDITORIAL.

Paid Medical Services and Private Practice.

The subject of the propriety of allowing so-called full-time paid medical officers in Government employ to engage in unrestricted private practice has often been dealt with in these pages. This question has also been repeatedly discussed in the local legislative council. All that has been achieved up to now are only indistinct apologies and vague promises from responsible members of the Government. The interests of the public and the medical profession demand that a solution should be found for this problem.

It is certainly very difficult for a group of men to deny themselves cheerfully lucrative practice which they have enjoyed for a number of years. But it is the duty of the Government, and it should be easy for them, to prevent the abuse of this privilege by their officers.

This privilege at present is pernicious, but we do not know how to characterize the innumerable ways by which this privilege is abused. We have often referred to the fancyful superiority claimed by these Government men for their professional skill and the great anxiety which they evince that their very superior knowledge should be availed of by the public. Repetition deceives some men into conviction. Thus many of these medical officers have probably come to a state of mind in which they believe that they are not only the best medical men but they are also the best fitted to undertake miscellaneous medical work. We believe there are full time officers in special departments like Bacteriology or Pathology who find an outlet for their specialist knowledge in being medical examiners for insurance societies, or by engaging in modified dispensary practice. Some of these officers have been school medical officers even in places where non-official medical men have been available. There are again some Government Medical Officers who in addition to their official duties and private practice are also medical officers for commercial firms A casual enquiry would be enough to bring out that there is hardly a sphere of medical practice in which the Government medical officers from the highest to the lowest do not compete with the private practitioner.

About a generation ago qualified medical men were few and they were mostly in Government employ. It might have been justifiable under those conditions to allow Government medical officers to engage in private practice. But at the present day when there are a very large number of qualified men outside the services, there is no excuse for the Government to continue this evil practice. In future, the Government should depend more and more on non-official agencies to provide adequate medical relief to the public. It is therefore essential that the Government should help the growth of a healthy independent medical profession. But this would not be possible if the private practitioner is thwarted at every step by the Government man.

It would be far better if the officers in Government service themselves realize these and bring about more healthy conditions. We are aware of a few individuals in service who scrupulously avoid ordinary private practice. They are unfortunately very few indeed. But if their example is not followed by an increasing number, it is the duty of the Government to step in and use all legitimate means to put down this growing evil.

BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

APRIL 1933.

The Rational Use of Digitalis.*

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We have in Digitalis a drug of specific value in certain cardiac conditions and one which is useful in the case of all patients suffering from cardiac decompensation that I feel it worth while to devote one entire evening to the history, the action and, above all, the rational method of handling this drug.

Withering, whose memorial aptly consists of a single flower of the fox-glove, introducd it into the medical world in 1785. He used it in cases of oedema for removing body fluids by increasing diuresis. But before Withering used it in medical practice it had been in use by the laity as a home remedy. Withering and his compeers used it indiscriminately in all cases of dropsy and naturally with varying success. The rationale of its action was not understood and with their indiscrimnate use and the natural sequence of the varying results is it any wonder that this drug which was ushered into the medical world with full flourish of trumpets went the way of other 'boomed' specifics and fell into disrepute? It fell to the lot of an humble general practitioner, the late Sir James Mackenzie to correctly interpret the mechanism of the various irregularities of the heart and, in 1911, to use Digitalis with startling results in auricular fibrillation and thus pave the way for Sir Thomas Lewis to explain its use, to establish its paramount position in the cardiac field and to bring back the drug to its rightful place in modern cardiac therapy.

Digitalis purpurea or the purple fox glove belongs the N. O. Scrophulariacæ and is found widely distributed in the temperate zone. Its active principles are still imperfectly known and less perfectly understood. Digitoxin and Digitalin are the two main active principles which have been separated and studied. The usual pharmaceutical preparations are made from the leaves. They are (1) Infusion, (2) Tincture, (3) Leaves, used in powder or tablet form. Digitalin (Nativelle) is a stable substance with a definite chemical composition largely used in France. The best preparations are those which contain all the active principles. The various preparations of digitalis vary in strength as the leaves are not constant in their active principle contents. So these have to be physiologically assayed and standardised. This physiological standardisation is effected by studying the lethal dosage on frogs and laterly on cats. The amount in milligrammes of the dry drug required to kill a frog weighing 30-40 grammes in 30 minutes is known as a *frog unit.* 1.5 grains of a good leaf contains 5 frog units. The amount required to kill a cat of 1 kilograme weight when a solution of the drug is given intravenously is taken as the *cat unit* or Hatcher's cat unit from the name of the discoverer of this type of assay. About 1·54 grains or 100 milligrammes of a good specimen approximates 1 cat unit. Besides the variation in the active contents and the consequent necessity for physiological assay it is also essential to remember that preparations of digitalis, especially fluid preparations, deteriorate rapidly with age and also when kept in mixtures or exposed to

* A lecture delivered before the South Indian Medical Union.

the air. So that it would be advisable to prescribe digitalis preparations either as leaves in tablet form, Digitalin (Nativelle) or when the ordinary pharmaceutical preparations are used in separate containers and in small quantities to prevent the use of any stock which has become. deficient in potency. All the reputable makers now send out their digitalis with the standard C.U. or F.U. strengrh and the date on the label. Leaf in powder, pill or tablet form is the most stable of the ordinary preparations and is the least irritant. Any of the preparations of digitalis may be used with equal effect but it would be wiser if the physician sticks to one or two standard preparations as he would then be better acquainted with their individual peculiarities and results. I have found concentrated Tinct. of Digitalis (B.W. & Co.) very satisfactory. It has given uniform results and not shown any perceptible clinical variation if used within the date mentioned on the label. Digitora, recently placed on the local market, is a powdered leaf tablet and has been tried with good results where a solid form of the drug has been preferred. Digalen is useful especially for hypodermic or intravenous injections. Nativelle's Digitalin granules form a convenient and reliable preparation. It is stable and of uniform strength and may be used either orally or by the hypodermic route. Digitalis suppositories are used on the continent (Europe) more widely than in other countries.

The object of administration of digitalis should be to digitalise the patient. Various methods are employed but the usual one is to follow a standard procedure like the Eggleston method. The Eggleston formula is based on the administration of digitalis in co relation with the body weight of the patient, and on the finding that 0·15 C.U. is required to digitalise a patient of 1 lb. body weight.

Eggleston's formula is as follows :—

$$\frac{C\,U \times {\cdot}15 \times W}{1\ 000} = L$$

$$\frac{C\,U \times {\cdot}15 \times W}{100} = T$$

$$\frac{C\,U \times {\cdot}15 \times W}{10} = I$$

where L, T and I represent the quantity of the dry leaf in grammes, tincture in c.c. and infusion in c.c. respectively, required for digitalising a person of W lbs. body weight.

Taking a concrete example, if it is required to find out the amount of the drug required to digitalise a person of 150 lbs. body weight, the amount of digitalis required would be 2.5 gmm, 22·5 c.c., 150 c.c. of the dry leaf, tincture, infusion respectively. It will be noticed from the above results that the relative dose value of these preparations are 1 : 10 : 60. In English measure 1 grain of the leaf may be said to be roughly equivalent to 10 minims of the tincture and one fluid dram of the infusion. Clinical observation shows that the effects of digitalis ars lessened in the presence of temperature and an appropriate increase in the dose is necessary in case fever is present. The amount given by the Eggleston formula required for digitalisation may be administered in a definite time interval depending on the urgency of the case. Another point to remember is the amount excreted in 24 hours. This amounts to an average of 20 minims. Thus to the amount calculated, a daily addition of 20 minims must be added to replace the amount excreted. Again taking a concrete example let me take the case of a patient weighing 150 lbs. The amount in tincture required for digitalisation would be 22·5 c.c. or 6 fluid drams. The period in which the digitalisation has to be effected depends on the urgency of the case. There are some

who consider that this should be effected in the shortest time in which case the dose may be given as follows : 2 drs. 1½ drs. ¾ dr. ½ dr. and so on, at 6 hourly intervals till the amount is given. If on the other hand it is decided to digitalise the patient in a longer period, say 4 days 80 minims to replace the excretion during the 4 days are added to the 6drs. and the total quantity divided and given in that period. As 4 to 6 hours must elapse before the digitalis is fully absorbed, it is wise to wait till that interval is over before repeating a dose. When big doses are being given the patient should be kept under constant care. The object is to be on the look out for toxic symptoms and this again is the reason why 6 hourly intervals are kept between doses Another mistake is in counting drops as equivalent to minims. Experiments have shown that 18-30 drops equalled 10 minims depending on the person and the speed with which the drops were poured out. A correct minim glass is essential. The drug is given alone and preferably after meals. In the case of gastric intolerance a preliminary dose of morphia 1/4 gr. hypodermically, would help the retention of digitalis. This intolerance is due to gastric congestion and should not be mistaken as a sign of digitalis intoxication. In most cases when the congestion is relieved the dose would be retained easily. The tincture or suppository may be given by rectum in case of very irritable stomachs. Once digitalisation is effected a daily holding dose of 20 minims of the tincture or 2 grains of the powder or Nativelle's Digitalin granule 1/240 gr. would suffice in maintaining the digitalis effect. In case of congestion of the liver Guy's pill 4 grs. would be a desirable preliminary measure.

The effect of the digitalis may be watched on the electro-cardiogram. In 4 hours to 8 hours the effect shows itself, first in a diminished amplitude and later in an inversion of the T wave.

It is essential to find out if any digitalis had been given in the preceding 10 days before commencing digitalisation treatment in which case the dose must be reduced and the patient carefully watched during the second administration. When gastro-intestinal symptoms appear within the first few doses it is not necessarily a contra-indication but only suggests a change in the method of administration. The effects of the drug on the pulse, urine and oedema should be carefully watched. So long as the urine remains scanty and deposits urate-full doses may be safely continued but when free diuresis is established and especially when the pulse rate falls below 70, the dose must be immediately reduced or the drug stopped. Excessive use of digitalis is no more desirable than insufficient use and the relative length of the systole has proved a delicate guide to the danger of over-dosage. The duration of the systole in relation to cycle-length would appear to be another valuable guide to digitalis therapy. These changes are much more delicate than in the P-R and often much clearer than in T. The Q-T interval shows a constant decrease in relation to R-R which was not decreased at all. This is an important index to the efficiency of the myocardium in recovery from heart failure and is interpreted as a direct action of digitalis on the myocardium.

Digitalis has, apart from its specific action on the heart, a local and a general action. Its local action is slightly irritant. Its general action is on the central nervous system, especially on the centres in the Medulla oblongata. It has a stimulating effect on the vagus and as such inhibits the heart. It reduces the conduction in the heart muscle and inhibits the

pace maker. The conductivity of the Bundle of His is depressed. This is questioned by some observers who, basing their views on the lack of response in the tachycardias of fever and hyper-thyroidism, raise the point that digitalis has no action on the Bundle and that shielding of the ventricle from excessive auricular stimuli is effected by its direct action on the musculature. The strength of the contraction of the heart is increased. Besides, it has a direct action on the heart muscle in producing a greater excitability and increased strength in the contractions. A certain amount of disparity between experimental and clinical results is found and is only natural. The experimental hearts are normal ones whilst the clinical results are based on the findings on pathological hearts. It has become possible only now to directly study the results on these pathological hearts, thanks to the development of orthodiagraphy and electro cardiograms. There is a difference in the action of digitalis on normal and pathological hearts. In *normal* hearts digitalis diminishes the output, reduces the size and decreases slightly the cardiac rate. No significant changes have been found in the arterial or venous pressure. Slight changes have been found in the electro-cardiogram on the T wave. All these return to normal in 48 hours to 3 weeks on withdrawal of the drug. In *congestive* failure the findings are entirely different. The volume output is diminished in congestive heart failure with or without Auricular fibrillation. The size of the heart is greater than when compensation exists. With the administration of digitalis an increase in the cardiac output and a diminished cardiac size are noticed; also an increased vital capacity, a diminished venous pressure and a marked slowing of the ventricular rate result, especially in those with a rheumatic aetiological factor. The characteristic changes in the T wave are constantly present. Digitalis was supposed to exert a tonic action on the muscular coat of the minute arteries thereby increasing the blood pressure. Modern experiments have, however, shown that the effect on the blood pressure is due to the improved circulation as the doses necessary to produce any effect on the arterial musculature are too large for safety and toxic to the heart. Digitalis usually increases the blood pressure but always lowers the diastolic pressure. Its action on the renal cells are indirect and the increased diuresis is due to the improved circulation.

There is this advantage that digitalis act as a true cardiac tonic, regulating the rhythm, diminishing the number of heart beats and strengthening the contractions of the heart besides having the same constant action and not becoming inert as a result of constant administration. It can be used in practically all cases of heart disease and is the remedy *par excellence* when decompensation is present. It is a specific for definite heart weakness or failure. Heart failure with high blood pressure, cardio-renal sclerosis, mitral disorders, mitral stenosis where the stenosis is not severe or where heart block is not present are some of the indications for its use. In chronic myocarditis continuous use of digitalis in small doses has been found useful. In chronic nephritis and arterio-sclerosis, even when compensation is present alternate medication with digitalis and diuretics have proved beneficial. It is often used as an adjuvant to other drugs in non-cardiac conditions like chronic bronchitis even when heart failure does not exist. There is a fallacy that digitalis should not be given to patients with high blood pressure, probably based on findings of experimental *healthy* animals. In man it does not raise the blood pressure except when failure is present where

the pressure is low. In such cases a rise in blood pressure is beneficial and in failure with hypertensive heart disease it is the failure and not the high pressure which calls for treatment. In non-fibrillation beneficial results are found as a result of increased tone and contraction of the dilated ventricle, due to the improved nutrition of the myocardium from increased ventricular output. But it is in auricular fibrillation and flutter and in the heart failure resulting from these that striking results are found. The theory of the action of digitalis in these cases is still unsettled. Shielding of the ventricles from excessive auricular stimuli by depression of the Bundle of His is the best accepted view. Digitalis has not been of use in most of the functional disturbances of the heart like palpitation, extrasystoles and tachycardia.

Sinus arrhythmia of a pronounced type, premature contractions especially when associated with a bigeminal pulse ventricular tachycardia, heart block are definite contra-indications to the administration of digitalis.

Large doses or too long continued or repeated doses induce toxic manifestations and are the clinical expressions of (*a*) paralysis of the vagus and predominant excitation of the sympathetic and vaso-constrictors. They manifest themselves in tachycardia, arrythmia, bigeminal pulse or pallor of the face, (*b*) direct action of digitalis on the mucous membrances. Gastro-intestinal disorders, a bitter taste, dryness of the throat, vomiting, cramps and diarrhœa are the results. Loss of appetite and vomiting may be due to local action or later of central action. As such it may be caused by any preparation and by whatever route the drug may be administered. How much of the gastro-intestinal irritation is due to digitalis and not due to gastric congestion is a point to be considered. In most cases gastric congestion is responsible and tolerance to the drug is established with improvement in the circulation. Neuhof's view is that extreme thirst and hunger pangs are amongst the earliest signs of digitalis toxaemia and that they precede other symptoms by 24-48 hours.

"Neither too much nor too little, neither too long nor too often" should be our guidance and I cannot do better than quote the dictum of Sydney Ringer which holds as true to-day as it did in the late seventies "we must endeavour to obtain the greatest therapeutic effect with the smallest possible dose."

Modern Methods in X-ray Examination of the Gastro-intestinal tract

BY P. RAMA RAU.

X-ray examination of the Gastro-intestinal tract is one of the most exacting diagnostic procedures to the radiologist and the recent advances in technique and modern conception of the X-ray appearances of mucous folds and rugae in health and disease as checked up by surgical exploration and autopsy have helped to lessen fallacies to a large extent. The principal object of this paper is to demonstrate the importance of X-ray study of the mucosa and rugae.

Oesophagus.—Normal oesophagus shows narrow longitudinal folds in its entire course; however, in cachectic individuals, folds might be definitely narrowed. Inflammatory changes are evidenced by marked widening of the rugae. The demonstration of this pathologic change is important not only in the not infrequent oesophagitis but more so in complications like diverticula, oesophageal hernias and peptic ulcers of the oesophagus.

Mucosal examination is a great help in determining the extent, localisation and diagnosis of carcinoma and the differentiation of benign from malignant strictures; diagnosis of cardiospasm is facilitated by the recognition of the continuity of the mucosal folds in the region of the Cardia. Diverticula and pseudo-diverticula though easily recognised, food particles in them may simulate malignancy. Enlarged mediastinal glands show a round defect in the wall with normal smooth rugae.

Stomach.—When well-filled a normal stomach shows concave or convex and rounded outlines; the borders; are never straight, angulated, or irregular in the abscence of a pathological condition. To take a picture of the rugae of the whole organ without compression it is usual to administer a thin suspension of barium, two table-spoonfuls in quarter litre of water—a P. A. view being taken in the prone position. However for more correctly seeing the different parts of the stomach on the screen, a couple of mouthfuls of barium emulsion are swallowed, and with gentle kneading with the gloved hand or the "Distinctor" (a wooden spoon-shaped contrivance with a suitable handle and a thin matallic ring designed by Prof. Holzknecht, which saves the radiologist unnecessary exposure of his hand to the rays) the opaque meal is moved to various parts of the organ. It is important that there be no mucus secretion, as otherwise the barium will slide down without filling the villae and the rugae cannot be visualised.

Normally we have parallel, longitudinal rugae along the lesser curvature confirming with its shape, transverse rugae along the greater curvature, and a combination of both in the region of the fundus. The pyloric antrum has transverse rugae running up towards the pyloric canal, parallel with the concavity of the lesser curvature. The lesser curvature is usually regular and smooth; the greater curvature shows irregularities caused by the filling of the transverse folds. Some consider them as separate structures, while others think they are caused by the spiral folds of the longitudinal rugae.

Large rugae and more irregular greater curvature are signs of gastritis. When the rugae are irregular and tortuous, but smooth, it is due to circumscribed elevations and depressions of the swollen mucous membrane of an acute gastritis. The smoothness and continuity with the normal rugae in the neighbourhood distinguishes it from ulcer (the rugae are seen to converge towards seat of ulcer) and cancer (the rugae are absent at the seat of infiltration). Gastritis might be general or localised in antrum as in alcoholic gastritis, or after a gastro-jejunostomy and the signs and irregularities are observed in the affected areas. In atrophic gastritis mucosal folds are flattened, narrowed, or obliterated; in hypertrophic type the mucosa is swollen with thick and wide folds specially in the antrum and near the greater curvature and may show polypoid changes. In anaemia the rugae are thinner.

In the neighbourhood of gastric ulcer and carcinoma wartlike granular surface of the mucosa is seen. Convergence of the mucosal folds towards the crater of ulcer is familiar. Symptoms of gastric ulcer will persist as long as there is any mucosal change, though the ulcer niche itself may have disappeared. Early neoplasms are recognised by persistent transverse folds or sudden breaks in their continuity, where you normally find longitudinal folds; or both the conditions might be present. The rigid irregular margin with defects, and the absence of rugae and peristalsis in cancer are noted as compared with the smooth round margins, peristalsis and

continuity of the rugae in benign conditions.

A circumscribed round defect with the rugae going smoothly around it is characteristric of polypus—when those are multiple the condition is gastric polyposis and gives rise to considerable disturbance of gastric function.

Benign ulcers are common in the lesser curvature; when near the pyloric canal on account of the associated spasm the patient comes early for relief. It calls for considerble attention to note the situation whether in the canal itself or one or the other side of it. The common deformity associated with the prepyloric ulcer however, is the snail shapped stomach caused by the flattening of the lesser curvature on account of the spastic contraction and pull exercised by the longitudinal muscles, resulting in an approach of the pylorus to the cardiac end. The greater curvature contiguous to the pyloric opening is drawn towards the lesser curvature by the coincident spasm of the circular muscle causing a rolling of the stomach itself. An incisura is noticed opposite the seat of ulcer. When there is no obstruction Hyperperistalsis is present and the duodenum may not be visible in profile, unless antrum is shifted with the distinctor. Other ulcers in the lesser curvature show slow peristalsis, retention of barium for longer time and the niche (crater caused by erosion of the mucosa and submucosa being filled by the contrast media). The niche accompanied by convergent rugae is a sign of active ulcer and the convergent rugae alone formed by the cicatrix that it has healed. Greater destruction into the muscle causes large niche; the barium filling may show a level with air above but the smooth outlines above and below, and the presence of rugae around differentiate it from malignancy. There is spastic incisura in the greater curvature and when it is considerable, dividing upper from lower part of stomach, is termed benign hourglass stomach. One has always to report whether it is functional, spasmodic, or organic caused by the fibrous scarry adhesions of surrounding inflammatory conditions.

Duodenum.— The duodenal bulb is that segment of the digestive tract between the pyloric ring and the descending portion of the duodenum. It presents a base, an apex, and four walls. The patient has to be rotated into the right and left oblique positions to see all the walls of the bulb, anterior, posterior and two lateral walls. The two lateral walls are impropely called margins or curvatures. The bulb is the preferred location for the ulcers, as a rule multiple (kissing ulcers)—occasionally single duodenal ulcers are seen—they may however be associated with ulcer or cancer in the stomach. The X-ray deformities of the cap vary according to location and stage of development of the ulcer, which may be situated at the base near the pylorus or at the periphery, and in the walls in their centre or margins. Normal duodenum shows smooth rugae continuous with the pylorus; ulceration shows deformities and thick and swollen mucosa. Three stages in the ulcer can be defined. (1) Initial ulcer, (2) ulcer with extensive areas of sclerosis and scarring and (3) the end results of sclerosis. In the first stage a niche is seen, form of a nail head or star defined on slight compression when situated on the anterior or posterior wall, and a niche in profile if on the lateral walls; and when the niche is filled with air (rare) a clear shadow may be seen. Presence of air in the niche is a sign of great penetration into the wall and that perforation is imminent. In the second stage when sclerosis of the walls has developed giving characteristic

deformities of the bulb we see (on slight compression) rigidity of the wall at the seat of the ulcer with convergence of rugae, eccentricity of the bulb in relation to the pylorus, incisura on the opposite non-sclerosed wall and pockets (recesses) caused by these incisurae. In the third stage we see varying degrees of rigidity of the cavity of the duodenum caused possibly by the various transitory stages of spastic incisura blending into the permanent retraction of one of the walls. The cap may be deformed by adhesions in cases of cholecystitis, or sometimes the latter symptoms may be caused by a doudenal ulcer. The pressure of an enlarged gall bladder shows a crescent shaped impression on the anterior wall at the apex, while in ulcers near the pylorus the recesses are characteristic.

Diverticula of the duodenum are usually located in the 2nd part, in the concavity of the curve, and show a continuity of the rugae. Careful examination in vertical and particularly in the prone position is essential to demonstrate the condition. If the cap or the second part is distended, and the pyloric canal is normal, there is probably some constriction or obstruction at the distal side. This is commonly caused by a compression about the superior mesenteric artery upon the 3rd part of the duodenum causing stasis and dilatation; sometimes duodenal peristalsis throwing contents back into stomach may be noticed with a patent pylorus. The duodenal cap is never deformed by conditions extra-duodenal.

Small Intestines.—The normal jejunum shows a feathery appearance on account of barium filling the valvulæ conniventes, and the ileum shows a more homogeneous shadow. The rugae are regular and circular. Multiple stenosis of T. B. are characterised by segments with irregularly dilated coils between; when any particular coil is more dilated, the concentric rugae and absence of haustration help to differentiate from the large intestines. Adhesions after laparotomy show a bunch of coils that retain barium for a longer period. Sometimes a loop of the ileum in an irreducible inguinal hernia is seen, and the meal is retained according to the extent of construction or obstruction, if any. In intestinal obstruction opaque meal or enema being too perilous to be practicable a simple radiogram of the distended abdomen is taken with the Potter Bucky diaphragm, soft rays at 75 K. V. P. and very gentle compressional without preparation of any kind, (neither enema, nor barium). Imprisoned gases outline with striking definition the position, size and extent of the distended bowel on the film, the large intestine being readily distinguished from the small by the position and the rugae shadows. The site of obstruction in the large bowel is marked by an abrupt ending of the gas distended bowel. The contracted bowel, empty of gas distal to obstruction, is not apparent on the film thus definitely marking out the seat of obstruction. When of longer duration, gas in the smaller intestines with horizontal fluid levels are seen in a film taken with the patient in the erect posture. (Contents of normal small intestines are of fluid consistency and no shadow of gas is seen on the film except in the caecum and colon. The fluid levels and gas are caused by congestion and fermentation in the coils. Experiments on dogs showed that gas was formed in obstructed loops after 4 to 10 hours.)

Intussusception is a typical disease of infancy 90 per cent. of which are ileocæcal and ileocolic. Barium enema carefully done and controlled with the aid of a horizontal fluoroscope is not only of great diagnostic value, but also a safe and good non-surgical method

of reduction in such conditions. Statistics show that non-surgical methods compare favourably with proper selection and careful handling.

Appendix.—The following method has been proved to visualise 100 per cent. of normal appendices, and the action is considered to be due to maintaining a fluid opaque media in the caecum and ascending colon, with retroperistalsis and filling of the appendix. In the morning three teaspoonfuls of mag. sulph. with quarter litre of barium emulsion, and the same evening plain barium emulsion are given. The patient is examined next morning and if the appendix is not filled another administration of the kind and a subsequent examination on the following day is performed. If it is not still visible a third procedure of the kind is undertaken. The mag. sulph. should produce mild diarrhoea, or else the quantity has to be increased or decreased according to action on the bowels. If the appendix does not fill on three administrations of the like mentioned, it is considered definitely abnormal and pathological. It is probably due to lumen being narrowed or obliterated by inflammatory changes. Of course, acute conditions are a contra-indication to this method.

Well filled, freely movable appendix with rounded tip, haustration and rugae is considered normal; and may be seen in various pictures about the caecum. Adhesions are characterised by a kinked, tortuous and elongated shadow. If it is not emptied for a long time it is a sign of disfunction and predisposition to inflammatory conditions. Localised pain and tenderness is always present in appendicular affections. It is always good to palpate and move about the caecum and appendix behind the screen and note points as tenderness, presence of lumps, masses and adhesions. It is important to palpate and separate the caecum and terminal coils of the ileum to more definitely and clearly see the appendix. Only part of the appendix may be filled, or the whole appendix may present segmented appearance with parts filled and the tip adherent. Adhesion of the single terminal coil of the ileum to the caecum is considered an associate sign of pathological appendix. Incompetence of the ileocaecal valve in the presence of good caecal tonus indicates pathology —usually appendicitis.

Large intestines,—The patient should have cleansing enemas before coming for X-ray examination, as faecal matter may simulate different conditions. The barium enema is given during fluoroscopy and the conditions noted; the patient is then asked to expel the contents of the bowels and examined again. The collapsed walls with barium in the folds in small quanities depict the condition of the rugae—tranverse and circular rugae—in the caecum, ascending and transverse colon; and longitudinal rugae in the sigmoid and rectum. The haustration of the colon and the musculature become more evident when disintended by air inflation. The rugae show cobweb appearence in ulceration. Filling defect in the lumen with absence of rugae is a sign of tumour infiltration; and irregular surroundings are due to sclerosis of malignancy. Deformities seen with the opaque enema and after expulsion of the contents are confimed as organic or abnormal conditions if they persist after air injection; or else they are due to spasm.

Common conditions in the colon are the various forms of colitis (dysenteries), cancer and tubercular affections. Diverticulosis is common in the sigmoid and is recognized by a small peduncle shaped shadow running out of the haustrations (dirverticula filled with barium). When inflamed, the condition is called diverticulitis and causes

considerable symptoms. Recognition of rugae in the diverticula help to differentiate from ulceration. The air injection after expulsion of barium enema helps greatly in the diagnosis of polyposis of the colon the contour of the polypoid growths outlined clearly against the air filled lumen. In conditions like colitis, dysentery and spastic colon the fine mucous membrane network is replaced by an irregular granular appearance or abnormally prominent folds. Superficial inflammations show spastic contractions only. Starlike rugae are caused by ulcers. When the walls are more sclerosed haustration disappears, and the lumen gets narrower (chronic colitis). Air injection shows the mottles of barium filling the ulcer crater and rings of barium in the folds around. In acute colitis the barium enema is almost completely expelled on account of the great quantity of inflammatory exudate and air inflation is a painful procedure. However, some barium globules in the form of a string along the long axis of the colon may be seen. When ulcers have penetrated into the walls, cul-de-scas of ulcer-base filled with barium are noticed. In the sigmoid this may produce any degree of obstruction consequent on the sclerosis and stenosis, and may present difficulties in diagnosing from cancer. Cancer, however, is more circumscribed, and rarely more than 2 to 4 c. m. in length. Ulcerative colitis shows extensive sclerosis and narrowing. In the rectum, ulcerative proctitis is usually accompained by sigmoiditis above, and shows angular and irregular filling defects. The large extent of the lesion again helps in the differential diagnosis from cancer of the rectum. It should be borne in mind that lack of haustration is present in cases of atony and dilation of the colon, but it is necessary to recognise that the dilation is more than three fingers' breadth and that there is no sclerosis of the walls.

The differential diagnosis of cancer and T. B. affections of the colon is so important, that I propose to study them together. Cancer is common in the sigmoid, less so in the right flexure of the colon, and rare in the caecum. T. B. is commonest in the caecum and very rare in the sigmoid colon. The Caecum may show large infiltrations which might be hyper-plastic type of T. B. or cancer. Cancer is more often situated around the ileocæcal valve. and in the medial part, while T. B. affection is usually lower in the caecum, to the lateral part of it and below the valve. Diseased caecum is characterised by barium being delayed (about 9 hours or more after meal) on account of spasm in the valve; and on account of the irritation of the lesion, barium is quickly passed up from the caecum. For T. B. of the caecum both barium meal and enema methods are advocated and air inflation. The terminal ileum and the part of the caecum below the valve get filled normally in about six hours after the meal. Spasm or organic stricture in the caecum causes the meal to go up the ascending colon without filling the part below the valve. Air inflation after expulsion of opaque enema shows irregular defects, tumour mass, organic narrowing, etc. If the rugae are normal, the defect is caused by traction and adhesions of a perivisceral process. If rugae are absent and the lesion is localised, it is cancer, for multiple carcinomas of colon are rare. If associated with inflammatory signs in other parts of the colon, and multiple stenosis in the terminal coils of the ileum, it is probably T. B. T.B. always causes insufficiency of the ileocaecal valve; in cancer on account of its situation the opening is more closed and obstructed. A pathological condition with a large defect in the upper part of the ascending colon with a normal shaped caecum is most probably a cancerous infiltration.

Cancer in the region of the caecum is usually an adenocarcinoma and is a rare condition in the caecum. The neighbouring area shows the normal rugae. A large filling defect in the lower and lateral part of the caecum, and the ascending colon showing mottles and signs of inflammation (by Weber's technique) is characteristic of hyperplastic T. B. Cancer in the sigmoid might cause definite obstruction and is characterised by irregular defects on both sides and narrowing of the bowel lumen.

ASSOCIATION NOTES.

Andhra Medical Conference.

The third Andhra Medical Conference commenced its sittings this morning (17th April) at 8 o'clock in the beautifully decorated Medical School Buildings in the presence of a large gathering of delegates from the Medical profession drawn from the different parts of Andhra Desa. Promiment among those present besides the local medical men were Major T. S. Sastri, Major K. V. R. Rao, Dr. T. S. Tirumurthi,Dr. A. R. Parasuram, Dr. H. V. Jogayya Sarma, Dr. M. A. Krishna Rao, Dr. S. V. Rama Rao, Dr. P. Rama Rao of the X-Ray Institute, Madras, Dr. Chiranjivi Amma, Miss Behara, Dr, Annapurnadevi and others.

Dr. A. M. Beal, M.D., President of the Guntur Medical Association and Chairman of the Reception Committee welcomed the delegates in a neat little speech and requested Dr. Ramachandra Rao, M.A., M.D., to take the chair.

PRESIDENTIAL ADDRESS.

In the course of his address, Dr. Ramachandra Rao thanked the members of the Conference for having elected him as the President of the Conference and paid a tribute to Guntur for its great traditions and the hospitality and generosity of its people.

Referring to the need of an organisation like the present, the doctor said that he was glad that the medical profession in the Andhradesa realised it The modern wonderful scientific progress had been the result of concentration and specialisation. Professional training and practice tended to make them narrow and short-sighted. They were apt to think " we are gods." But association with other professional men and women would stimulate their thoughts, broaden their vision and humble them in their own estimation. Unlike the lawyer who moved and had his being in the wide world, they were apt to move in narrow, nay, vicious circles. They needed at times to get out of themselves and breathe in the spirit of freedom untrammelled by routine professional tradition. Let them try to come out of their narrow grooves whenever they could and get the courage to assert that they had a right to live, live well, live a complete harmonious life.

METHOD OF TREATMENT OF DISEASES.

The speaker next dwelt on the importance to build the edifice of the medical profession on the solid rock of truth. Let them have the courage to face it, to own it and be prepared to pay the cost of the search. Expatiating on some aspects of the question, the speaker proceeded to say that man was not merely a bundle of physiological organs but he was mind and spirit. Therefore the treatment, to be effective, should deal not only with diseased tissue or the incapacitated organ but should be directed to grip the mind and touch the soul of the patient. The equipment of the doctor should be of the highest order, and should tend in the direction of mental development

and moral aspiration. The physician should have a trained intellectual outlook on life and also sterling moral character. Not only the skill but also the personality of the doctor should make an appeal to the patient. He should not be content to be a mere scavenger, removing the accumulation of the filth of the disease but be a teacher of the art of right conduct. He should be able to say, " follow me and get well and keep well for the rest of your days." The speaker next drew attention to the importance of studying psychology and getting interested in psycho-therapeutics.

THE GUIDING PRINCIPLE OF THE PROFESSION.

Continuing the speaker said: The economic factor was not the guiding principle of the medical profession, though the medical man or woman like all other labourers was certainly entitled to his or her hire. They ought to be assured of a living wage, a wage that would ensure a high degree of efficiency. But they should remember that efficiency was maintained by keeping once's hand constantly in the work. They should strive to cure whether they were sufficiently paid for or not. There was no profession like theirs where undue haste to get rich was fraught with grave consequences. The honour of the profession was kept up by those men and women whom no sordid pecuniary considerations could ever tempt to swerve from the path of strict professional conduct. Their temptations were no doubt great, particularly as they tried to climb the lower rungs of the ladder, but they should develop a code of professional honour which even the new recruits to the profession should disdain to break. Neither silver nor gold nor cheap popularity should be able to seduce a doctor to behave in an unprofessional way towards his patients or fellow practitioners. They ought to be able to build up a code of professional decorum apart from pecuniary considerations in this country also.

It should be remembered that they were not the repositories of all knowledge and that they were not always infallible. Their profession being conservative they were apt to exaggerate their importance. But science never knew finality. While it held to the truth, it had to keep its eyes and ears open for the new light that might come in pouring through a thousand channels. It was unscientific to be cocksure of anything. As scientists they should be prepared to accept the truth from whatever source it might come and in whatever garb.

ALLOPATHIC AND INDIGENOUS SYSTEMS.

The speaker continuing, said that the allopathic system should not assume an air of superiority towards the other systems in vogue in the country and treat them with scant courtesy. They should remember that the vast bulk of the people of this country patronised Ayurvedic and Unani systems. As rational men and women they were bound to study those systems also and cull out whatever truths they might find in them so that they might help to cure diseases when it baffed their ordinary methods of treatment. They could not afford to lose sight of the rich and priceless treasures which their ancestors had accumulated for them, in the course of their experience and research. Of course, they should try to modernise them and adapt them to the present-day needs.

The speaker next stressed the importance of knowing their limitations and said that to know something of everything would not carry them very far. But within the limitations of human beings they could, if they made up their minds, make an honest and determined attempt to know every-

thing of something. In other words, they should try to specialise. The speaker was aware of the danger of extreme specialisation. They were beginning to learn that organs in the human body were wonderfully interdependent and that disease in any one of them could not be properly understood without making a thorough study of the conditions in the other organs. The body responded as a whole and the specialist could not possibly live in a water-tight compartment. Specialised proficiency depended on a high order of general professional knowledge. But from the general they had to turn to the special if they desired to make adequate progress. They should try to specialise in the subjects in which they were most interested. They owed a debt of gratitude to others for their work and sacrifice in the quest of scientific truth, and the only way in which they could pay back their gratitude was by following their footsteps and trying to contribute their mite to the sum of human knowledge.

The speaker in conclusion emphasised the need for medical men and women to escape from their sphere of work and visit places to see how work was done by others. They could not with their limitations increase the span of human life. They had to be content with the task of soothing the pillow of pain. Let them do small things in a big way ; let them sacrifice their time, comfort and money to make the pillow of pain as comfortable as possible. The speaker wished that there should be a constant stream of young people in our country determined to do some research work either in laboratories or in hospitials quite content with the wage of a labourer. The tree of medical knowledge had all along been watered with the blood of martyrs in its cause. The choicest reward for the best of them could be the consciousness that they had tried to walk in the foot-prints of the benefactors of the human race.

Opening of Medical Exhibition.

The Medical Exhibition organised by the Reception Committee of the third Andhra Medical Conference which met to-day, was opened last evening in the Medical School buildings by Dr. C. Ramanujaiya, District Medical Officer, Guntur, in the presence of a large gathering of the members of the Medical profession. Among those who exhibited their wares, mention may be made of the Bengal Chemical Pharmaceutical Co., the Bengal Immunity, the Paragon products, Sur, I. G. Gajjar of Bombay, Markandeya Pharmacy of Bezwada, Bose's Laboratory, Bactro Clinical of Calcutta and the Madras Medical Co-operative Society, Ltd.,

Resolutions.

The third Andhra Medical Conference discused and passed resolutions yesterday.

At the outset, the Conference placed on record its sense of profound sorrow at the demise of Dr. Miss Kuglar, Sir Ronald Ross, Drs. V. Hanumantha Rao, G. L. Kantha Rao, K. Ahobala Rao, Rao Sahib M. Seshadri Reddi, J. M. Sighomoney, A. G. Atchayya Naidu, B. V. Narasimhayya and V. V. Narasimham and conveyed its condolences to the members of the bereaved families.

The Conference reiterated such of those resolutions of the second Andhra Medical Conference with necessary modifications and which had not yet been given effect to by the bodies concerned and authorised the Standing Committee to include the same in the body of the resolutions to be passed at the Conference. Disapproval was expressed of the policy of the Government in referring the proposed All-

India Medical Council Bill to a select committee without any references and a committee was appointed consisting of the President and two other members to make representations to the select committee whenever necessary.

The Government were requested to constitute District Councils on the lines of District Educational Councils for the proper management of subsidised rural medical relief scheme. The Madras and Andhra Universities were requested to permit the medical licentiates to qualify for the M. B. B. S. degree with not less than two years' additional training in professional subjects withont insisting upon any additional general educational qualifications. The conference desired to affiliate the Andhra Medical Aossociation to the Indian Medical Association and requested the Standing Committee to go in to the matter. As the incidence of venereal diseases was on the increase, the Conference requested the Indian Government to reduce the fee for the Khan's test and W. R. to Rs 2 and 3 respectively and expressed heartfelt thanks to the Superintendent of Kuglar's Hospital, Guntur, who volunteered to do the Khan's test for Rs. 3.

The Conference suggested to the Government the desirability of taking evidence from the members of the public and the profession on the items of reference to the Committee on Honorary Medical Relief made by the Government to the Committee and requested the Standing Committee to draft a memorandum for presenting the same to the Government Committee within a fornight. The Madras Medical Council was requested to recommend to the Government the registration of practitioners of allopathic system who possess qualifications already recognised by the Medical Council and which are not in the published schedule. Another resolution requested the Government to transfer the Lady Willingdon Medical School to Guntur.

Resolutions were also passed appointing a Standing Committee consisting of 16 members, one from each Telugu district, requesting the Andhra Medical profession to contribute liberally to the memorial funds of Drs. Kuglar, Ahobalo Rao and Hanumantha Rao and accepting the invitation to hold the next Conference in the Kistna District.

Dr. Beel, Chairman of the Reception Committee, then thanked the delegates for having gone over to Guntur and made the Conference a success.

PRESIDENT'S CONCLUDING SPEECH.

The President, in his concluding speech, expressed his great satisfaction at the fact that the Conference established the spirit of comradeship. The democratic factor was the spirit of service and the medical profession was eminently fitted to serve as the cementing element of unity and goodwill. Doctors, the speaker continued to say, drew no invidious distinctions of caste, creed, colour or race and he hoped that the Conference had laid the foundations of unity.

The President went on to say that, though this Conference was only the third of its kind, the papers read thereat were of high quality and were quite an inspiration. He hoped that the spirit which was fostered at this Conference would be kept up and at the next session many more would give their message of speciality. He concluded by saying that the Andhra Medical Conference was the expression of the Andhra Medical Association.

The Conference then terminated.

"The Hindu."

Kistna Medical Association.

ETHICS OF MEDICAL PROFESSION.

DR. D. S. RAMACHANDRA RAO'S ADDRESS.

The second anniversary of the Kistna District Medical Association was celebrated on the 8th April in the premises of the local Cosmopolitan Club.

The proceedings commenced with the presentation of the annual report by the Secretary of the association. The report was duly adopted. Dr. D. S. Ramchandra Rao then spoke on "Medical ethics in private practice" for about an hour. Dr. T. S. Tirumurti, presiding.

The speaker paid a tribute to the memory of the late Dt. K. Ahobala Rao and observed that his death had created a great void in the Andhra medical world, which it was impossible to fill.

Proceeding, the speaker deplored that medical ethics as such did not find a place in the curriculum of medical studies and felt that ethics ought to form the very foundation of medical practice. It was only when practice was based on ethical conceptions that it would stand edified and unnobled. In Great Britain 80 to 90 per cent of medical men started as a rule as assistants to private medical practitioners, and as many of them would be in the advantageous position of being able to get on without having to rely on their own earning they would be in a position to imbibe and observe medical ethics in practice. But here in India conditions were quite different. The medical graduate was left entirely on his own meagre resoures in this country and started generally as a private practitioner. That was a very undesirable state of things to picture. The great majority of the people, even to the extent of 75 per cent of the population, were found to rely on indigenous systems of treatment for their needs. Whether a change in favour of the Allopathic system—which in itself was a hypothetical proposition—would do the country good, the speaker observed, was a matter of great doubt. If it could be said as an economic law that demand created supply, it was equally true that supply, created demand, psychologically considered. Experience showed that the fashion was to bring into existence a thing and to make one believe that one could not get on without it. The complaint that the profession was becoming overcrowded was under the circumstances a misnomer. If the practitioner could really make the need for him felt, then there was no ground for the complaint that the profession was overcrowded.

Continuing, the speaker said it could not, however, be denied that competition between the Allopathic practitioner and the indigenous physician was keen and that the strife was on the increase. The result was that the atmosphere had become vitiated. Medical ralief ought to develop into a great co-operative concern if real public good ought to accrue from it. The need for organising the profession on such lines could not be exaggerated. A spirit of willing co-operation and mutual understanding should inform the profession. Senior men should always be prepared to lend a helping hand to juniors and private medical practitioners should not look upon the "Hospital-men" as their enemies.

Concluding, Dr. Ramachandra Rao laid stress on the need for organising the profession on sound lines and observed that in the absence of an efficient organisation the medical profession in the country could not stand

up and assert itself against the domination of external agencies like the British Medical Association.

Dr. Tirumurti brought the proceedings to a close with his concluding remarks.

After dinner, the session met again in the evening.

Dr. Tirumurti delivered an interesting address on "Recent advances in Pathology." Dr. Ramachandra Rao presiding.

The function concluded with a social gathering in the evening.

"The Hindu."

Madras Medical College.

Reservation of Seats for Travancoreans.

The Government of Travancore announce that six seats are reserved for Travancore students in the Medical College, Madras, for the medical course commencing 1st July, 1933, of which two are intended for women candidates if they are forthcoming. The selection of the students rests with the Travancore Government. No fees will be levied by the Madras Government in respect of candidates so selected but they will have to pay to the Travancore Government fees at the same rates as are paid by students belonging to the Madras Presidency, women students being allowed the concession of half these rates. Travancoreans seeking admission to the Medical College for the course commencing July 1933 are required to apply in forms prescribed by the Medical College to the Durbar Physician, Travancore, before the 1st June 1933.

Medical Education in Bihar.

Observations in Annual Report.

That overcrowding in the medical profession is lending to a lower ethical standard among the medical practitioners, and that the administration will eventually be forced to solve this difficult question, are the principal points stressed by Col. L. Cook in his triennial report of the working of hospitals in Bihar and Orissa, just issued.

The Colonel says that the argument that overcrowding was not yet so acute that it called for drastic measures, was only putting off the evil day. Referring to the language handicap of medical students, the report says: "The standard of preliminary education required is not a high one, and his knowledge of English in which language he is supposed to study during the curriculum is not of a sufficiently high standard to enable him to read and understand with any facility his text-books. He is, therefore, handicapped from the commencement, but when it is considered that the curriculum extends over four years in which time he is overwhelmed with collateral subjects, the result of medical progress, one is not surprised that the average licentiate has only a superficial knowledge of his profession, judged by modern allopathic standards."

The report pleads for the extension of the course from four to five years.

CORRESPONDENCE.

To the Editor,

The Bulletin of the S. I. M. U.

Sir,

I read the personnel of the second Honorary Committee in the March issue of the Bulletin and was very pleased to see one good non-official's name in it. But last evening I heard that at the one meeting of the committee already held all that was settled was that one honorary physician should replace one salaried physician at a second class city hospital. I also heard that it was suggested that no further meetings of the committee were necessary as there was nothing more to be done "at the present stage." All the same one more meeting is probable.

In the extracts of Mr. Arasu's speeches you quote in the same issue, the speaker gives figures from the report of the Finance Committee in which there is a sanction of a sum of Rs. 50,139 (recurring) and Rs. 13,700 (non-recurring) for employment of additional staff for the Ear, Nose and Throat department and provision is also made for Rs. 15,400 (recurring) and Rs. 440 (non-recurring) for the X-ray Institute the Government General Hospital.

The outcome of the mountain of the first Honorary Committee labouring last year we all are aware of. Your editorial note about the meeting of the licentiates association at Gana Mandir at which the then Chief Minister referred to the fiasco of the first Honorary Committee's report and asked the medical profession to send up more independent-minded and more outspoken representatives to the second Honorary Committee's that was then to be appointed and about the re-election of Dr. U. Rama Rao to the Chairmanship of the licentiates association, has not impressed us a bit though we have forgiven you in backing up No. 1 of your Editorial Board. But if the second committee fails like the first one I would request you to desist from backing up any more members on your editorial board unless you can give sounder reasons in his support.

With the universal financial depression and high taxation on the one hand and the demand for increased salaried staff in the medical department on the other, the non-official members of this committee must muster courage, gather all available information about administering hospitals not only in this presidency but outside it and put up a bold and strong fight against the stereotyped views of service men that will be most forcefully, not to say artfully, placed before them, and effect something radical rational and substantial. If after proper preparation they cannot achieve anything substantial they should either walk out or issue a minority report. We can have no respect for unanimous reports when they are practically dictated by officials and meekly signed by non-officials.

There are now in Madras several men with higher qualifications and experience. We have M.D's., M.S'., F.R.C.S'. and D.O.M.S'., several with special work like in Radiology, E.N.T., Cardiology at accepted centres of specialising as Vienna etc.; and several others who in their practice of over twenty years have proved their competency and gained the confidence of the whole Presidency. All these should be really utilised to relieve salaried men for work in the mofussil. The Government plea that the services of these men are saving the government from employing extra staff which would have been necessiated by the increase in medical work would on close inspection be easily proved to be incorrect. At least 50 per cent of this honorary

staff could well replace a part of the salaried staff in city hospitals. Granting that even this is too much to convince a service-ridden government the least that an honorary committee could get done is to obtain, for these honoraries when once approved, a status equal in all respects, except that of salary, to that of salaried men of their rank. This step should be done not only in fairness to these men but also in reply to the 2nd term of reference of the committee namely the best way of obtaining suitable men to serve as honoraries For, unless the men already working as honoraries in this Presidency are treated as they ought to be and are elsewhere treated a better class of fresh graduates could not be incited to join their ranks. On this point another radical change must be brought about however powerfully opposed by the indolent senior salaried staff. All the under staff of all the teaching Hospitals in the City at first and in the Presidency afterwards must be replaced by House Surgeon, House Physician, Resident Surgical and Medical officers as in English hospitals. For all these subordinate appointments (I include the Assistant Surgeons and Assistant Lecturers belonging to the Provincial service working in the clinical hospitals under this category) are grounds for the training of the post-graduates. Their terms of appointment and duties should be the same as in English hospitals. There are so-called house surgeons in Madras but their duties are not and cannot be the same as in English hospitals as long as salaried Assistant Surgeons are kept over them. For these latter do the duties of the English House Surgeon.

It is from men trained like this that good honoraries spring up in England, and not by any arbitrary and stupid grades as set by the first honorary committee.

If junior salaried officers be allowed to take up these House Surgeoncies on the same terms as other House Surgeons their grievance of difficient post graduate training owing to the monopoly of the influenced few to city appointments will be removed.

Let this second honorary committee concentrate at least on these two points if they could not do more.

MADRAS, 3-5-1933. — Your sincerely, "X. Y. Z"

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